CHAPTER V

BILLING PROCEDURES

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INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program. Two major areas are covered in this chapter:

- **General Information -** This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures -** Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Payment Methodology

DMAS has established a flat rate for each level of service for home health agencies (HHAs) by peer group (effective for dates of service on and after July 1, 1993). There are three peer groups: (i) the Department of Health's HHAs, (ii) non-Department of Health HHAs whose operating offices are located in the Virginia portion of the Washington DC-MD-VA metropolitan statistical area, and (iii) non-Department of Health HHAs whose operating offices are located in the rest of Virginia. The use of the Health Care Financing Administration (CMS) designation of urban metropolitan statistical areas (MSAs) is incorporated in determining the appropriate peer group for these classifications.

The Department of Health's agencies are placed in a separate peer group due to their unique cost characteristics (only one consolidated cost report is filed for all Department of Health agencies).

Rates are calculated as follows:

a. Each home health agency will be placed in its appropriate peer group.

b. Home health agencies' Medicaid cost per visit (exclusive of medical supplies costs) will be obtained from the 1989 cost-settled Medicaid Cost Reports filed by freestanding HHAs. Costs will be inflated to a common point in time (June 30, 1991) by using the percent of change in the moving average factor of the Data Resources Inc. (DRI), National Forecast Tables for the Home Health Agency Market Basket.

c. To determine the flat rate per visit effective July 1, 1993, the following methodology will be utilized.

    1. The peer group HHA's per visit rates shall be ranked and weighted by the number of Medicaid visits per discipline to determine a median rate per visit for each peer group at July 1, 1991.

    2. The HHA's peer group median rate per visit for each peer group at July 1,

1991, shall be the interim peer group rate for calculating the update through January 1, 1992. The interim peer group rate shall be updated by 100 percent of historical inflation from July 1, 1991 through December 31, 1992, and shall become the final interim peer group rate which shall be updated by 50 percent of the forecasted inflation to the end of December 31, 1993, to establish the final peer group rates. The lower of the final peer group rates or the Medicare upper limit at January 1, 1993, will be effective for payments from July 1, 1993 though December 1993.

3. Separate rates shall be provided for the initial assessment, follow-up, and comprehensive visits for skilled nursing and for the initial assessment and follow-up visits for physical therapy, occupational therapy, and speech therapy. The comprehensive rate shall be 200 percent of the follow-up rate, and the initial assessment rates shall be fifteen dollars ($15.00) higher than the follow-up rates. The lower of the peer group median or Medicare upper limits shall be adjusted as appropriate to assure budget neutrality when the higher rates for the comprehensive and initial assessment visits are calculated.

d. The fee schedule shall be adjusted annually on or about January 1, based on the percent of change in the moving average of Data Resources, Inc., National Forecast Tables for the Home Health Agency Market Basket determined in the third quarter of the previous calendar year. The method to calculate the annual update shall be:

1. All subsequent year peer group rates shall be calculated utilizing the previous final interim peer group rate established on January 1 becoming the interim peer group rate at December 31 each year. The interim peer group rate shall be updated for 100 percent of historical inflation for the previous twelve months, January 1 through December 31, and shall become the final interim peer group rate which shall be updated by 50 percent of the forecasted inflation for the subsequent twelve months, January 1 through December 31.

2. The annual update shall be compared to the Medicare upper limit per visit in effect on each January 1, and the HHA's shall receive the lower of the annual update or the Medicare upper limit per visit as the final peer group rate.

See the peer group table of rates in “EXHIBITS” at the end of this chapter.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (888) 829-5373 and choose Option 2 (EDI).
Fax number: (804)-273-6797

First Health's website: http://virginia.fhsc.com
E-mail: edivmap@fhsc.com

Mailing Address:

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

Transportation Costs

Extraordinary transportation costs to and from a Medicaid recipient's home that are not also covered by Medicare may be recovered by the home health agency if the recipient resides outside of a 15-mile radius of the home health agency. Payment will be set at a rate per mile as established by the General Services Administration in the Federal Travel Regulations. (Federal Travel Regulations are published in the *Federal Register*.)

If a visit is within the 15-mile radius, the transportation cost is included in the visit rate; therefore, no additional reimbursement for transportation will be made. For a home health agency to receive reimbursement for transportation, the recipient must be receiving Medicaid home health services.

Durable Medical Equipment and Supplies

Billable durable medical equipment and supplies, defined as equipment and supplies which remain in the home beyond the time of the visit, will be reimbursed separately. **To bill for durable medical equipment (DME), the agency must also be enrolled as a DME vendor.** Expendable medical supplies left in the home by a nurse will be reimbursed separately only when billed on the CMS-1500 (12-90) using a DME provider number. Refer to the Virginia Medicaid *DME and Supplies Manual* for complete billing instructions.

Third-Party Liability

Since Medicaid is always the payer of last resort, before billing Medicaid the provider must seek payment from any other source where the recipient may have coverage for the services provided. Information regarding other sources can be obtained from the recipient or from the Medicaid identification card. Information showing the payments collected from other sources must be included on the Medicaid invoices. It is the responsibility of the provider to ensure that an individual who receives Medicaid home health services is Medicaid-eligible on the date of service.

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are

encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the claim on paper with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or
she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the letter from the local department of social services indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits.)

- **Rejected or Denied Claims** - Rejected or denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 (12-90) invoice as explained under the "Instructions for the Use of the CMS-1500 (12-90) Billing Form" elsewhere in this chapter.

  - **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from

Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

- Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form.

- Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

  Department of Medical Assistance Services
  Practitioner
  P. O. Box 27444
  Richmond, Virginia 23261-7444

  Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt except in the following circumstances:

  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

  - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

  - This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.

  - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those affected by it.

  The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date

of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

- **Other Primary Insurance** – The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service**. If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment Medicaid has been made, an adjustment or void should be filed at that time.

- **Electronic Billing** – Providers may submit claims electronically. Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid Claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information, contact:

  EDI Coordinator
  FIRST HEALTH Services Corporation
  P.O. Box 26228
  Richmond, Virginia 23230

BILLING INVOICES

The requirements for the submission of home health billing information require the use of the UB-92 HCFA-1450 Universal Claim Form.

REPLENISHMENT OF BILLING MATERIALS

The UB 92 HCFA-1450, Universal Claim Form is accepted by most third party payers. This form is used for home health billing. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

<u>The UB 92 HCFA-1450 claim form will not be provided by DMAS.</u>

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS website (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a *record* of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (888)-829-5373 and choose Option 2 (EDI).

CLIA CERTIFICATION

Any laboratory claims submitted by a Home Health agency will be denied if no CLIA certificate and identification number are on file with DMAS. This requirement implements the federal Clinical Laboratory Improvement Amendment of 1988. To obtain a CLIA certificate and number or to obtain information about CLIA, call or write the Virginia Department of Health (VDH) at:

VDH Office of Health Facility Regulation
3600 Centre, Suite 216
3600 W. Broad Street
Richmond, Virginia 23230
804-367-2107

DMAS will deny claims for services outside of the CLIA certificate type, reason 480 (provider not CLIA certified to perform procedure).

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by using the Web-based Automated Response System. See Chapter 1 for more information.

BILLING INSTRUCTIONS

To bill for home health services, the UB-92 HCFA-1450 universal claim form must be used. The following instructions for the claim form have numbered items corresponding to the fields on the form.

IMPORTANT: Medicaid eligibility is determined on a monthly basis. It is the responsibility of the provider to ensure that an individual who receives Medicaid home health services is Medicaid-eligible on the date of service.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after October 15, 2003, and all local service codes will no longer be accepted for claims with dates of service after October 15, 2003. All claims submitted with dates of service after October 15, 2003 will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before October 15, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after October 16, 2003, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after this date.

The transactions for hospital claims include:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- TADs (Turnaround Documents) – Unprocessable claim due to missing or invalid data. The claim is retained in the system and a TAD identifying the missing or invalid data is returned to the provider. These TADs should be corrected and returned as directed to allow completion of the processing of the original claim. It is not necessary to resubmit the claim on a new invoice.

- Remittance Voucher

- **Approval** – Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).

- **Denied** – Payment cannot be approved because of the reason stated on the remittance voucher.

- **No Response** – If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

INSTRUCTIONS FOR COMPLETING THE UB-92 HCFA-1450 UNIVERSAL CLAIM FORM

The UB-92 HCFA-1450 is a universally-accepted claim form that is required when billing DMAS for covered services rendered by participating home health agencies. The UB-92 has a multi-purpose format so that it can be used for submitting original, adjusted, or voided claims. This is accomplished by coding transaction-specific information in certain locators on the UB-92 form. This form is readily available from printers. The UB-92 HCFA-1450 **will not** be provided by DMAS.

<u>The UB-92: General Information</u>

- All dates used on the UB-92 HCFA-1450 should be two digits each for the day, the month, and the year (e.g., 010199) with the exception of Locator 14, Patient Birthdate, which requires four digits for the year.

- Note: Do not use any slashes, dashes, or spaces in dates.

- Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

- When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

- Do not record cost reduction copayments on this form.

- Use envelopes supplied by DMAS to submit claims for processing.

- To adjust a previously paid claim, complete the UB-92 HCFA-1450 to reflect the proper conditions, services, and charges.

    - Type of Bill (Locator 4) - Enter codes 336.

    - Locator 37 - Enter the nine-digit claim reference number of the paid claim

to be adjusted. The claim reference number appears on the remittance voucher.

- Remarks (Locator 84) - Enter an explanation for the adjustment.

- To void a previously paid claim, complete the following data elements on the UB-92 HCFA-1450:

  - Type of Bill (Locator 4) - Enter codes 338.

  - ICN/DCN (Locator 37) - Enter the nine-digit claim reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.

  - Payer Indicator (Locator 50) - Enter "Medicaid" here.

  - Medicaid Provider Number (Locator 51) - Enter the Medicaid provider number.

  - Recipient ID Number (Locator 60) - Enter the recipient's 12-digit Virginia Medicaid number.

SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter I under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary physician or on referral from the primary care physician must place the primary physician's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted enrollee is treated on referral from the primary physician, enter the primary physician's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI Billing (Electronic Claims)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross reference number, and entered into the system, it is placed in one of the following categories:

Turnaround Document Letter (TAD)

If lines on an invoice are completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to First Health. The claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

UB-92 Invoice Instructions

The following description outlines the process for completing the UB-92 HCFA-1450. It includes Medicaid-specific information and should be used to supplement the material included in the *State UB-92 Manual*.

Locator		Instructions
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required** (if applicable)	**PATIENT CONTROL NUMBER** - Medicaid will accept an account number which does not exceed 17 alphanumeric characters.

Locator		Instructions
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 333 Original Bill 336 Adjustment Invoice 338 Void Invoice
5	Not Required	**FED. TAX No.**
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. If the total days of service exceeds 31 days, use additional billing invoices. Claims submitted which exceed the 31-day limitation will be denied, "Limit of 31 Days Per Billing Invoice Exceeded."
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid-covered days as applicable.
8	Not required	N-CD. (Non-Covered Days)
9	Not required	C-ID. (Coinsurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	Unlabeled Field	
12	**Required**	**PATIENT NAME** - Enter the patient's name - last, first, and middle initial.
13	**Required**	**PATIENT ADDRESS** - Enter the patient's address.
14	**Required**	**BIRTHDATE** - Enter the month, date, and full year (MMDDYYYY).

Locator		Instructions
15	**Required**	**SEX** - Enter the sex of the patient as recorded on the date of admission, outpatient service, or start of care.
16	Optional	MS (Patient's Marital Status)
17	**Required**	**DATE (Admission Date)** - Enter the date of admission for inpatient. Enter the date of service for outpatient.
18	Not required	HR (Admission Hour)
19	Not required	TYPE (Type of Admission)
20	Not required	SRC (Source of Admission)
21	Not required	D HR (Discharge Hour)
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the ending date in Statement Covers Period (Locator 6).
23	**Required (if applicable)**	**MEDICAL RECORD NO.** - Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: This number should not be substituted for the Patient Control Number (Locator 3) which is assigned by the provider to facilitate retrieval of the individual financial record.
24-30	**Required (if applicable)**	**CONDITION CODES** - Enter the code(s) in numerical sequence (starting with 01) which identify conditions relating to this bill that may affect payer processing. Include the Special Program Indicator codes listed below, if applicable: A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION DANGER TO LIFE A8 INDUCED ABORTION VICTIM RAPE/INCEST
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURENCE CODES AND DATES** - Enter the code (s) in numerical sequence (starting with 01) and

Locator		Instructions
		the associated date to define a significant event relating to this bill that may affect payer processing.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES** - Enter the code (s) and related dates that identify an event related to the payment of this claim.
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the nine-digit claim reference number of the paid claim to be adjusted or voided. Use the appropriate type of bill (locator 4) in combination with the reference number from the incorrect claim. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). NOTE: A=Primary Payer B=Secondary Payer C=Tertiary Payer Cross Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	Optional	RESPONSIBLE PARTY NAME AND ADDRESS
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim.

Locator	Instructions
	One of the following codes **must** be used: 82 No Other Coverage 83 Billed and Paid (enter the amount paid by the primary carrier) 85 Billed Not Covered/No Payment Other codes may be used if applicable.
42 **Required**	**REV. CD. (Revenue Codes)** - Enter the appropriate revenue code(s) for the service provided as follows: **CODE: Three digits, right justified, no leading zeros.**

Locator 42 Revenue Code	Locator 43 Description
550	Skilled Nursing Assessment
551	Skilled Nursing Care, Follow-Up Care
552	Skilled Nursing Care, Comprehensive Visit
571	Home Health Aide Visit
420	Physical Therapy, Home Health Assessment
421	Physical Therapy, Home Health Follow-Up Visit
430	Occupational Therapy, Home Health Assessment
431	Occupational Therapy, Home Health Follow-Up Visit
444	Speech-Language Services, Home Health Assessment
441	Speech-Language Services, Home Health Follow-Up Visit
542	Non-Emergency Transportation, Per Mile Beyond 15 Miles
001	Total Charge (required)

43 **Required**	**DESCRIPTION** - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the above information).
44 **Required (if applicable)**	**HCPCS/RATES**[1]

[1] The current local HCPCS codes will no longer be required for billing purposes upon the full transition to revenue codes for Home Health billing. Please begin use of Revenue Codes with dates of service after October 15, 2003. Local/national code crosswalk is available on the DMAS website.

Locator		Instructions
45	**Required (if applicable)**	**SERV. DATE** - Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, speech-language therapy, skilled nursing, or home health aide visit or session (1 visit = 1 unit). Do not use CPT modality units.
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges must include only covered charges.
48	Optional	**NON-COVERED CHARGES -** Reflects non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "001" for TOTAL non-covered charges. (Enter the grand total for both total charges and non-covered charges on the same line of revenue code "001.")
49	Unlabeled Field	
50	**A-C. Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C.
51	**A-C Required**	**PROVIDER NO.** - The Medicaid Provider ID # is seven digits. Enter this number on the appropriate line. A = Primary B = Secondary C = Tertiary

Locator		Instructions
52	A-C Not Required	REL INFO (Release Information - Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits - Certification Indicator)
54	A, B, C, P Not Required	PRIOR PAYMENTS (Payers and Patients)
55	A, B, C, P Not Required	EST AMOUNT DUE
56	Unlabeled Field	
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the name on the Medicaid ID card. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**A-C Required**	**P. REL** - Enter the code indicating the relationship of the insured to the patient. Refer to the *State UB-92 Manual* for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT. - SSN - HIC - ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. NOTE: The Medicaid recipient ID# is 12 digits.

Locator		Instructions
61	**A-C Required (if applicable)**	**GROUP NAME** - Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable)**	**INSURANCE GROUP NO.** - Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.
63	**A-C Required (if applicable)**	**TREATMENT AUTHORIZATION CODES** - Enter the number indicating that the treatment is authorized by the payer. This number is required for extensions of PT, OT, and Speech-Language Therapy and Skilled Nursing Visits on the DMAS-351.
64	**A-C Required (if applicable)**	**ESC (Employment Status Code)** - Enter the code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME** - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION** - Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD. (Principal Diagnosis Code)** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the ICD-9-CM diagnosis code(s) for diagnoses other than principal (if any). **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.** - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician. **DO NOT USE DECIMALS.**
77	Not required	E-CODE (External Cause of Injury Code)

Locator		Instructions
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 - HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**PRINCIPAL PROCEDURE CODE AND DATE** - Enter one of the ICD-9-CM procedure codes listed below. 9300-9339 Physical Therapy 9383 Occupational Therapy 9372-9373 Speech Language Pathology **DO NOT USE DECIMALS.** For outpatient claims, a procedure code must appear in this locator when revenue codes 360-369 or Codes 420-429, 430-439, and 440-449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected. For revenue codes other than those identified above used in Locator 42, the claims will not be rejected due to the lack of a procedure code in this locator. Procedure code 8909 will be used by Virginia Medicaid if the locator is left blank.
81	**A-E Required (if applicable)**	**OTHER PROCEDURE CODES AND DATES** - Enter the code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**
82	**Required**	**ATTENDING PHYS. ID. -** Enter the seven-digit number assigned by Medicaid for the physician who performs the principal procedure.
83	**A Required (if**	

Locator		Instructions
	applicable)	**OTHER PHYS. ID.** - Enter the provider number assigned by Medicaid for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit. This is required for all MEDALLION patients even though the PCP may be listed in Locator 82. For MEDALLION patients referred to an outpatient clinic, enter the provider ID number assigned by Medicaid for the PCP who authorized the outpatient visit. For Client Medical Management (CMM) patients referred to the emergency room by the PCP, enter the provider ID number and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate. Enter the PCP provider number for all inpatient stays. **THE PCP # MUST BE IN LOCATOR 83-Aa.**
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37). Also, if there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Also, provide other information necessary to adjudicate the claim.
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. (Required for paper claims only)
86	**Required**	**DATE** - Enter the date on which the bill is submitted to Medicaid. (Required for paper claims only)

Forward the first payer copy with any attachments for consideration of payment, using the envelope supplied by Virginia Medicaid, or address it to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261

Maintain the Institution copy in the provider files for future reference.

EXHIBITS

TABLE OF CONTENTS

APPROVED OMB NO. 0938-0279

1 TYPE OF BILL	2	3 PATIENT CONTROL NO.

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a											A
b											B
											C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
57		**DUE FROM PATIENT ▶**				

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
							OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

OCR / Original

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)* **M M D D C C Y Y** **Date of Service** **Sequence Number (5 digits)**

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	Provider Name:

Enrollee Identification Number:

Enrollee Last Name:	**First:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)**_____

COMMENTS:_____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us. Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS – 3

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 123456789070120031 2345.)
IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number	02 Last Name	03 First Name
04 Recipient ID Number	05 Patient's Account Number	06 Recipient's HIB Number (Medicare)

1

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

2

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

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3

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

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4

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

24 Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

DMAS - 30 R 6/03

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE INVOICE, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the 9-digit Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the

reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission.

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

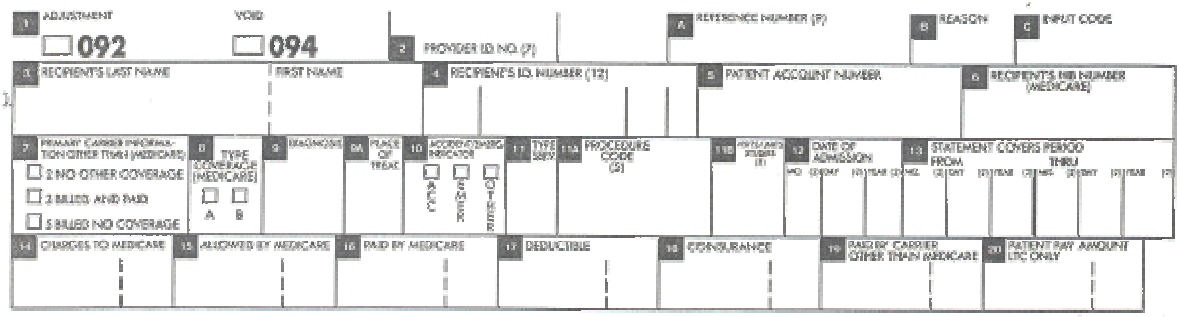
Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 6/96

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS-31 (REVISED 6/96)

Purpose To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 2A **Reference Number** - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Block 3 **Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.

Block 4 **Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 5 **Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.

Block 6 **Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier

pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate national place of service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

Accident - Possible third-party recovery
Emergency - Not an accident
Other - If none of the above

Block 11 **Type of Service** - Enter the appropriate *national* code describing the type of service:

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this blank. Use the appropriate national procedure code modifier if applicable

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare.(Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the

Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and

The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

PA SERVICE TYPES

CATEGORY	DESCRIPTION	PA TYPE #	HIPAA PA #	LOC
MENTAL HEALTH/SA	Outpatient Psych Services	0050	A8	
	Substance Abuse (FAMIS)	0051	AI	
EPSDT Non-State Plan Services	Private Duty Nursing	0090	74	
	Personal Care	0091	42	
	EPSDT DME	0092	12	
	EPSDT Inpatient Psych	0093	A7	
DME	Home	0100	12	
	Nursing Home	0101	12	
	Tech Waiver	0102	12	
REHAB	Intensive Inpt.	0200	AB	
	CORF	0201	AC	
	Special Vent Contract	0202	Non-EDI Request	
	Special Contract (Out of State)	0203	Non-EDI Request	
	Outpt. Rehab	0204	AC	
Medical Support	Organ Transplants	0300	70	
	Out of State Services	0301	1	
	Surgical/Invasive	0302	2	
	Prosthetics	0303	75	
	Muscular/Skeletal Devices	0304	BS	
	Vision	0305	AL	
	Other	0306	1	
Hospital	Inpatient Med/Surg	0400	48	
	Inpatient Psych	0401	48	
Home Health	Home Health	0500	44	
Community MHMR Services	Community MHMR Services	0600	A4	

ECM	**Elderly Case Management**	**0625**	**3**	
TFC CM	**Treatment Foster Care Case Mgmt.**	**0700**	**3**	
Residential Treatment	**CSA**	**0750**	**A7**	
	Non-CSA	**0751**	**A7**	
Dental Services	**Children, Under 21 years old**	**0800**	**35**	
	Orthodontic, Under 21 years old	**0801**	**38**	
	Adult, Over 21 years old	**0850**	**35**	
CATEGORY	**DESCRIPTION**	**PA TYPE #**	**HIPAA PA #**	**LOC**
Community Based Care (CBC) Waivers	**Elderly & Disabled Waiver (E&D)**	**0900**	**54**	**9**
	IFDDS (Individual and Family Development Disability Services)	**0902**	**54**	**R**
	AIDS Waiver (Respite Care 720 Hrs. Max.)	**0920**	**54**	**E**
	Mental Retardation Waiver (MR)	**0940**	**54**	**Y**
	CDPAS (Consumer Directed Personal Assistant Services)	**0950**	**54**	**Q**
	Tech Waiver (PDN & Respite Care 360 Hrs. Max.)	**0960**	**54**	**A**